Please forward the signed authorization to the address listed below:

UnitedHealthcare Central Escalation Unit
PO Box 30573
Salt Lake City, UT 84130-0573

For questions please call toll-free 1-877-842-3210

Member Authorization Form for a Designated Representative to Appeal a Determination

DATE: _____

Member Name: _____

Member ID #: _____

I hereby authorize _____ to appeal UnitedHealthcare's determination concerning:

_____

_____

_____

on my behalf, as my Designated Representative, and, as part of the appeal, I hereby authorize UnitedHealtcare in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative concerning the following:

All medical and financial information contained in my insurance file, including but not limited to treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder and HIV status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed.

I understand this information is privileged and confidential and will only be released as specified in this Authorization, or as required or permitted by law. This authorization is valid for a period of one year.

_____

Signature of Member or Legal Guardian/Representative

_____

___Signature of Witness ___Designated Representative (Check One)

_____

Name of Witness/Designated Representative (Please Print)

_____

Title (if on provider's staff) or Relationship to Member